Supreme Court, U.S.
FILED
07-790 DEC 12 2007
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No. (1)

IN THE

Supreme Court of the United States

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,

Petitioner,

vs.

RENATE KING,

Respondent.

On Petition for a Writ of Certiorari to the Louisiana Second Circuit Court of Appeal

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether a state court violated *Chevron* deference, the Supremacy Clause of the U.S. Constitution and undermined national regulatory uniformity, in the Medicaid context, by finding that state Medicaid eligibility policy – validly implemented through a Centers for Medicare and Medicaid Services approved state plan amendment – is too restrictive when the amended policy provisions are not contained in 42 U.S.C. § 1396 or any pertinent federal Medicaid statute or regulation.

2. Whether state courts should be confined to the federal parameters of administrative adjudication judicial review that complement judicial deference to administrative statutory interpretations made by the authorized participants of the federal-state regulatory framework governing the federally funded Medicaid program.

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OPINION BELOW

The Louisiana Supreme Court's writ of certiorari denial is reported at 963 So. 2d 1001 (La. 9/14/07) and is reprinted in the Appendix at 46a-47a. The Louisiana Second Circuit Court of Appeal opinion is reported at 956 So. 2d 666 (La. App. 2 Cir. 2007) and is reprinted in the Appendix at 1a-23a. The 26th Judicial District Court of Louisiana did not publish an opinion in this case. Its written reasons for judgment are reprinted in the Appendix at 26a-28a.

JURISDICTION

The Louisiana Supreme Court filed it decision, to deny a writ of certiorari, on September 14, 2007. This Court has jurisdiction under 28 U.S.C. §1257(a) to review the state court's decision on a writ of certiorari.

STATUTORY PROVISIONS INVOLVED

U.S.C.A. Const. Art. 6, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every

state shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

42 U.S.C. §1396a(a)(1)

A State plan for medical assistance must –

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

42 U.S.C. §1396p(c)(1)(A)

In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) . . .

42 C.F.R. §430.14

CMS regional staff reviews State plans and plan amendments, discusses any issues with the Medicaid agency, and consults with central office staff on questions regarding application of Federal policy.

42 C.F.R. §430.15

(a) Basis for action.

(1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.

(2) Guidelines are furnished to assist in the interpretation of the regulations.

(b) Approval authority. The Regional Administrator exercises delegated authority to approve the State plan and plan amendments on the basis of policy statements and precedents previously approved by the Administrator.

STATEMENT OF THE CASE

This matter concerns an important issue, regarding cooperative federal- state regulatory policy implementations – at the state level – affecting the allocation of federal funds, that needs to be addressed by this Court for purposes of restoring deference – at the state court level – to Medicaid related administrative statutory interpretations and applications. A favorable pronouncement by this Court regarding deference – in the Medicaid context – will not only restore state court removed validity to the Louisiana Department of Health and Hospital's ("DHH") and the Centers for Medicare and Medicaid Services' ("CMS") regulatory authority, but will operate as an immediate mitigating directive to all Medicaid participating states' courts that deference is federally required to ensure national uniformity in the allocation of a large amount of federal funds. And will further emphasize that this mandated deference is intended to ensure that state courts do not substitute their judgment and federal statutory interpretations for those of the federally authorized participants in an administrative regulatory framework that requires specialized institutional knowledge and expertise of those participants. This Court's mandated State court adherence – in all Medicaid states – can have the collective impact of positively affecting national uniformity in the allocation of federal Medicaid funds.

Louisiana's state level administrator of the cooperative federal-state Medicaid program – along with CMS – has been tacitly stripped of federally

delegated regulatory authority by a state court that refuses to follow the federal mandate of administrative deference as it is extended to the Medicaid regulatory framework. Unfortunately, the Louisiana Supreme Court has refused to exercise its discretionary jurisdiction to review the erroneous decision below, which is necessary to restore the validity of the Medicaid regulatory framework and its warranted deference at the state level. This is not the first instance where the Louisiana Supreme Court has refused to intervene and rectify the state appellate courts gross departure from the mandated deference required to be given to the regulatory decisions of the administrator of this cooperative federal-state program. The effect of the decision below is that the federally compliant state level administrator of this cooperative federal-state program – with a majority of its funding derived from federal funds – has been judicially deemed to have no regulatory authority to implement CMS approved State plan amended Medicaid policy – which undermines DHH and CMS' joint effort to shepherd federal funds to their congressionally intended recipients and administratively close a gap in the transfer of resources provisions enacted by 42 U.S.C. §1396p(c)(1)(A).

A. Factual Background

There are no factual disputes in this matter that began with an application for Medicaid long term care benefits filed with DHH, on behalf of Renate King ("King"), on or about August 8, 2005. King was denied long term care benefits on the basis of excess resources. King's Medicaid application listed countable resources totaling $224,244.62. These resources consisted of a checking account valued at $20,070.19, an annuity with Fidelity and Guaranty Life Insurance Company purchased on July 22, 2005 and valued at $138,881.22, excess property valued at $44,000.00 and combined miscellaneous resources valued at $21,293.21. Since King has a non-institutionalized spouse, shared and separate resources were counted and the spousal impoverishment maintenance needs and resource standards policy was applied to King's case. At the time, the spousal impoverishment exemption amount was $95,100.00 and this amount was deducted from King's total countable resource amount of $224,244.62, which resulted in a total amount of $129,144.62 in excess resources. This far exceeded the allowable resource limit of $3,000.00. From King's perspective, if the Fidelity and Guaranty Life Insurance Company annuity was not counted as a resource, the total amount of countable resources would have been $85,353.40. When applying the $95,100.00 exemption amount to this figure, King would have a countable resource amount well under the $3,000.00 limit.

B. Proceedings Below

In making the ineligibility determination at issue, DHH applied Medicaid Eligibility Manual policy I-1634.2 entitled "Annuities" to the Fidelity and Guaranty Life Insurance Company annuity held by King's spouse, William D. King. This policy is part of Louisiana's Medicaid Eligibility Manual ("MEM") and is mirrored by a supporting Louisiana Register Rule entitled "Treatment of Annuities" that is published in the Louisiana Register.[1] The implementing Medicaid eligibility policy found at I-1634.2 of Louisiana's Medicaid Eligibility Manual was approved by the Centers for Medicare and Medicaid Services as an amendment to Louisiana's State Plan.[2] Therefore, the policy at issue — MEM I-1634.2 — is supported by a validly promulgated Rule and incorporated into Louisiana's State Plan, through a CMS approved amendment, which renders it — in its entirety — a valid and applicable policy compliant with the preemptive federal statutes and regulatory framework. The annuity at issue failed to

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[1] First promulgated as an Emergency Rule, with an effective date of January 1, 2003 and a provision that implementation was contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. See Louisiana Register Vol. 29, No. 1, p. 6, January 20, 2003. The final Rule is found at Louisiana Register Vol. 29, No. 12, p. 2802, December 20, 2003.

[2] DHH's Medicaid director received a letter from CMS' regional office in Dallas, Texas, in October 2003, approving the Treatment of Annuities Rule and the implementing policy found in MEM I-1634.2 retroactive to January 1, 2003. A copy of the State plan amendment is reprinted in the Appendix at

meet all of the criterion of MEM I-1634.2, specifically the requirement that DHH be named as the residual beneficiary. DHH's administrative law judge rendered an administrative decision upholding the ineligibility determination. Appendix at 34a-43a. The state district court reversed the administrative law judge for the written reasons found in the Appendix at 26a-29a.

The Court of Appeal, in upholding the state district court's reversal, recognized that it is well established that generally state regulations that are inconsistent with federal law are invalid under the Supremacy Clause. Appendix at 17a. And further recognized that the Supremacy Clause applies to the regulatory scheme promulgated under the Medicaid act. Appendix at 17a. Its holding that DHH's State plan amendment was preempted by federal law was not only inconsistent with this recognition, but a gross departure from the regulatory uniformity necessary for the effective stewardship of the nationally allocated federal Medicaid funds. This was not the first instance raising the federal question of whether the State plan amendment has the force of federal law. The question was also raised, argued and considered at the district court level as indicated by the district court's analysis and conclusions – regarding said issue – in the written reasons for judgment found in the Appendix at 26a-29a.

REASONS FOR GRANTING THE PETITION

I. THE LOUISIANA SECOND CIRCUIT COURT OF APPEAL'S DECISION CONFLICTS WITH THIS COURT'S *CHEVRON* DEFERENCE AND ITS APPLICATION – BY FEDERAL APPELLATE COURTS – TO CMS STATE PLAN AMENDMENT RELATED STATUTORY INTERPRETATIONS.

In *Chevron, U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), this Court held that the power of an administrative agency to administer a congressionally created ... program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress," 467 U.S. at 843, *quoting Morton v. Ruiz*, 415 U.S. 199 (1974). If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute. Sometimes the legislative delegation to an agency on a particular question is implicit rather than explicit. In such a case, a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency. *Id.* This Court further held that it has long recognized that considerable weight should be

accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations. 467 U.S. at 844.

In *Texas v. United States Department of Health and Human Services*, 61 F. 3d 438, 440 (5th Cir. 1995), the court extended this *Chevron* deference, in the Medicaid context, by applying it to a question of whether CMS properly interpreted the Medicaid statute to disallow an amendment to a State plan, and upheld the CMS action. More recently, *Chevron* deference has been further applied, by United States appellate courts, in their review of the statutory and regulatory framework of the Medicaid program. In *Alaska v. Centers for Medicare and Medicaid Services*, 424 F. 3d 931, 938 (9th Cir. 2005), the court held that the Medicaid Act prescribes a laundry list of requirements that this state plan 'must' satisfy, *citing* 42 U.S.C. §1396a(a), and an extensive body of regulations implements these requirements. The Secretary 'shall approve' any state plan (or amendment) that fulfills these statutory and regulatory conditions, *citing* 42 U.S.C. §1396a(b), and has delegated this authority to the CMS Administrator, *citing* 42 C.F.R. §430.15(b). And in *West Virginia v. Thompson*, 475 F. 3d 204, 208 (4th Cir. 2007), the court recognized that the Secretary of the U.S. Department of Health and Human Services has delegated approval authority to the Administrator of CMS, a component of the Secretary's department. The court viewed West Virginia's challenge of the Secretary's construction of the Medicaid statute through the lens of *Chevron*, *Id.*, and concluded that the Medicaid statute is a

prototypical 'complex and highly technical regulatory program' benefiting from expert administration, which makes deference particularly warranted. 475 F. 3d at 212. And further held that the administrative process through which state plan amendments are considered also counsels deference, recognizing that CMS regional staff review state plans and proposed amendments, discuss concerns with the Medicaid agency, and consult with central office staff on questions of federal policy, *citing* 42 C.F.R, §430.14. *Id.*

In light of these federal jurisprudential pronouncements, clearly the opinion below is a gross departure from and violation of the federally mandated deference required of courts reviewing the statutory interpretations and applications of an administrator operating under federally delegated authority. And it impinges federal governance of the Medicaid program.

II. A DIRECTIVE REGARDING UNIFORM DEFERENCE TO THE MEDICAID REGULATORY FRAMEWORK – FROM THIS COURT – IS NECESSARY TO SAFEGUARD THE PROPER EXPENDITURE OF FEDERAL FUNDS AT THE STATE LEVEL AND IMMEDIATELY MITIGATE ANY FURTHER STATE COURT DEPARTURE FROM THIS REQUIRED DEFERENCE.

Recent rulings by Louisiana's courts of appeal indicate that Louisiana's state judiciary has, for the most part, given zero deference to administrative

interpretations and applications of Medicaid eligibility policy. And the Louisiana Supreme Court has – on three occasions – refused to entertain requests to rectify this violation of federal law. *Ouzts v. State, Dept. of Health and Hospitals*, 888 So. 2d 918 (La. App. 2 Cir. 2004); *Smith v. State, Dept. of Health and Hospitals*, 895 So. 2d 735 (La. App. 2 Cir. 2005), *rehearing denied* (3/31/05), *writ denied*, 904 So. 2d 701 (La. 2005); *Carpenter v. State, Dept. of Health and Hospitals*, 944 So. 2d 604 (La. App. 1 Cir. 2006), *rehearing denied* (10/25/06), *writ denied* 948 So. 2d 174 (La. 2007); *Brewton v. State Dept. of Health and Hospitals*, 956 So. 2d 15 (La. App. 5 Cir. 2007).

While the opinion below is a state court decision invalidating DHH and CMS' regulation of Louisiana's Medicaid program, the issue of how *Chevron* deference should be applied to federally compliant state level Medicaid regulatory interpretations and actions –considered from this Court's perspective – is ripe for review. A pronouncement by this Court, on this issue, will have the force necessary to ensure that state courts adhere to the federal requirements intended to ensure the proper expenditure of federal Medicaid funds that rely on their proper allocation through the cooperative federal-state administrative framework.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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Judgment rendered April 4, 2007. Application for rehearing may be filed within the delay allowed by art. 2166. La. C.C.P.

No. 42,071-CA

COURT OF APPEAL
SECOND CIRCUIT
STATE OF LOUISIANA

* * * * *

RENATE KING *Plaintiff-Appellee*

v

SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Defendant-Appellant

* * * * *

Appealed from the
Twenty-Sixth Judicial District Court for the
Parish of Bossier, Louisiana
Trial Court No. 119,360

Honorable Bruce Martin Bolin, Judge

NEAL R. ELLIOTT, JR.

Counsel for Appellant

PESNELL LAW FIRM
By: W. Alan Pesnell

Counsel for Appellee

* * * * *

Before BROWN, GASKINS and Lolley, JJ.

LOLLEY, J.

The Louisiana Department of Health and Hospitals ("LDHH") appeals a judgment from the Twenty-Sixth Judicial District Court, Parish of Bossier, State of Louisiana, which held that the state guidelines applicable to annuities were unenforceable, because they were more restrictive than federal guidelines. For the following reasons, we affirm.

FACTS

Renate King filed an application with the LDHH for Medicaid Long Term Care ("LTC") benefits on August 8, 2005. Mrs. King was denied LTC benefits on the basis of excess resources. Her countable resources included an annuity her husband, William King, acquired valued at $138,881.22. According to the LDHH, the annuity would be considered a non-countable resource if it

had fulfilled Louisiana's requirement that Mr. King name the State of Louisiana as the residual beneficiary on the annuity. Mrs. King's excess resources totaled $129,144.62 which far exceeded all resource limits.

Details of Mr. King's annuity

The commercial annuity at issue was paid with a single premium of $138,881.22 and lasted a period of two years, well within the life expectancy of Mr. King. The annuity paid a monthly amount of $5,792.14 to Mr. King providing a payback in excess of the amount paid for the annuity. The annuity was sold by Fidelity and Guaranty Life Insurance Company, in the State of Louisiana, and provides for no balloon payment. The annuity contract clearly contains a Medicaid Single Premium Immediate Annuity Waiver Endorsement setting forth that the annuity is non-transferable, non-

assignable, totally and permanently irrevocable, and has no cash value. LDHH admits that the annuity is actuarialy sound. The beneficiary of the annuity is the William D. King Estate.

Procedural History

LDHH notified Mrs. King that she was ineligible for LTC benefits by a notice dated October 18, 2005. Mrs. King requested a fair hearing on November 15, 2005. An administrative hearing was held regarding the ineligibility determination, and the administrative law judge ("ALJ") rendered a decision upholding the LDHH determination. Mrs. King filed a petition to review, and oral arguments were heard by the trial court on August 7, 2006. The trial court reversed the ALJ decision, and found Mrs. King eligible for LTC benefits. The trial court issued written reasons and stated that "Louisiana's requirement that a person name the state as a

beneficiary on an annuity is unenforceable and cannot be used to deny benefits." It is from this ruling that the LDHH appeals.

LAW AND DISCUSSION

In the instant case, we must determine the legal soundness of Louisiana's requirement than an annuitant name the state as the residual beneficiary for the annuity in order to be designated as a non-countable resource at the time of Mrs. King's application. This requirement is commonly referred as a "state-payback" provision. Mrs. King argues that as a result of the "state-payback" provision, the Louisiana medicaid eligibility methods are unlawfully more restrictive and do not comport with the preemptive federal guidelines.

Medicaid and Applicable Provisions

Congress enacted Title XIX of the Social Security Act, or the Medicaid Act, in 1965,

establishing a cooperative federal-state program in which the federal government reimburses states for a portion of the cost of medical care for needy persons. 42 U.S.C. §1396 *et seq.; Schweiker v. Gray Panthers*, 453 U.S. 34, 101 S. Ct. 2633, 69 L. Ed. 2d 460 (1981). State participation in the program is voluntary, but states choosing to participate must comply with the federal statute's requirements. *Harris v. McRae*, 448 U.S. 297, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980). The test for Medicaid eligibility is essentially a needs-based test, with coverage being denied if the applicant exceed a ceiling in countable resources. The Medicare Catastrophic Coverage Act of 1998 ("MCCA"), 42 U.S.C. §1396r-5, amended the Medicaid Act to establish a mechanism to protect couples from being forced to deplete their assets to qualify for Medicaid.

The MCCA established impoverishment provisions by which a portion of a couple's resources are protected and not considered available to pay for nursing care expenses. In determining eligibility, the community spouse resource allowance ("CSRA") is not considered available to the institutionalized spouse, but all resources above the CSRA must be spent for that spouse in order for that spouse to be eligible. The CSRA is determined by calculating the total of all of the couple's resources, whether jointly or separately owned, as of the time a spouse is institutionalized. Half of that total is then allocated to each spouse. *Wisconsin Dept. of Health and Family Services v. Blumer*, 534 U.S. 473, 122 S. Ct. 962, 151 L. Ed. 2d 935, (2002). At the time of Mrs. King's application, the CSRA was in the amount of

$95,100.00 and the allowable resource limit was $2,000.00.

In the instant case, a relevant provision in the MCCA is 42 U.S.C. §1396r-5(b)(1) which states, "During any month in which an institutionalized spouse is in the institution . . . no income of the community spouse shall be deemed available to the institutionalized spouse." However, more stringent requirements were put in place to restrict the ability of individuals to shelter resources in order to qualify for Medicaid as part of the Omnibus Budget Reconciliation Act of 1993. 42 U.S.C. §1396p.

Louisiana, through the LDHH, created a Medicaid Eligibility Manual ("MEM") giving effect to the federal statutes that establish our state standards for Medicaid benefits, including eligibility

for LTC nursing facilities. MEM §§ B-100, B-300. Eligibility for LTC vendor payments is specifically based on the applicant's need, calculated on the applicant's resources, including income and certain property. MEM § H-831.4.

Applicable definitions

The term "resource" is defined in the Social Security regulations, 20 C.F.R. § 416.1201(a), and states:

> For purposes of this subpart L, resources means cash or other liquid assets[1] or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

---

[1] The term "liquid resources" is defined in the regulations as: . . . cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. 20 C.F.R. § 416.1201(b).

As a general rule, a revocable trust is a resource for purposes of Medicaid eligibility, and an irrevocable trust is not a resource. *See Smith v. Secretary, Louisiana Dept. of Health and Hospitals*, 39,368 (La. App. 2d Cir. 03/02/05), 895 So. 2d 735; 42 U.S.C. 1392(p)(d) *et seq.* A "trust" includes any legal instrument or device that is similar to a trust, ***but includes an annuity only to such extent and in such manner as the Secretary of the Department of Human Services specifies***." (Emphasis added.) 42 U.S.C. § 1396p(d)(6).

Congress delegated broad authority to the Center of Medicare and Medicaid Services ("CMS") through the Secretary of the Department of Health and Human Services, to define eligibility requirements for Medicaid consistent with the statutory scheme and the reasonable exercise of the

delegated power. *Schweiker, supra; State of La. v. United States Dept. of Health and Human Services*, 905 F. 2d 877 (5th Cir. 1990). The CMS has a manual ("CMS manual") which sets forth the directives of the Secretary of the Department of Health and Human Services. Pursuant to the power delegated to CMS, annuities are defined in the CMS manual which states:

> The annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.
>
> Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as a part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purposes of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than

> fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.
>
> . . .If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty.

At issue in this case is whether, at the time of Mrs. Kings application, MEM I-1634.2 as promulgated, was enforceable in light of the federal guidelines. Louisiana's MEM I-1634.2 specifically states:

> For Medicaid eligibility purposes an annuity is considered a legal instrument or device similar to a trust. An annuity is defined as a contract or agreement by which one receives fixed non variable payments on an investment for a lifetime or a specified number of years. An annuity containing a balloon payment will be considered an available resource. An annuity purchased by or for an individual using that individual's assets will be considered an

available resource unless all of the following criteria are met.

The annuity:

1. is irrevocable;

2. pays out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the annuitant; and,

3. ***names the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime;*** and,

4. is issued by an issuer or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

Annuities which do not meet all of the above criteria must be amended to comply with these requirements. Annuities which do not provide for pay out of principal and interest in equal monthly installments and for which documentation is received from the issuing company that the "pay out" arrangement

> cannot be changed, will be considered to meet the new requirements once amended to name the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime.

(Emphasis added).

LDHH believes it followed the rulemaking procedure necessary to promulgate the state's treatment of annuities. Specifically, LDHH points out that they obtained the required approval from CMS, allowing implementation of the requirement at issue. LDHH also makes much of the correspond-dence between a CMS employee and the King's annuity representative who had inquired into the validity of MEM I-1634.2. The CMS response, not surprisingly, stated "first, let me assure you that Louisiana's plan amendment fully comports with federal statutes and regulations, which is why it was

approved by CMS." Mrs. King, on the other hand, points to the CMS manual and other federal statutes which allow annuities, such as Mr. King's annuity, to be a non-countable resource without the "state-payback" provision. Thus, Mrs. King argues, this more restrictive state imposed language is unenforceable.

Standard of Review

As explained in our prior decision, *Cox v. Secretary, Louisiana Dept. of Health and Hospitals*, 41,391 (La. App. 2d Cir. 08/25/06), 939 So. 2d 550, when reviewing an administrative final decision in an adjudication proceeding, the trial court functions as an appellate court. Once a final judgment is rendered by the trial court, an aggrieved party may seek review of same by appeal to the appropriate to the appropriate appellate court. On review of the trial court's judgment, no deference is

owed by the court of appeal to the factual findings or legal conclusions of the trial court, just as no deference is owed by the Louisiana Supreme Court to factual findings or legal conclusions of the court of appeal. Thus, an appellate court sitting in review of an administrative agency reviews the findings and decision of the administrative agency and not the decision of the trial court.

The applicable standard of review is set forth in La. R.S. 49:964. Subsection F of La. R.S. 49:964 provides that a reviewing court is confined to the record established before the agency (except in cases of alleged irregularity in procedure before the agency). A reviewing court's function is not to weigh *de novo* the available evidence and to substitute its judgment for that of the agency. Nevertheless, the trial court and the court of appeal have the authority

to reverse or modify the decision of the agency if substantial rights of the party seeking review have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (1) in violation of constitutional or statutory provisions; (2) in excess of the agency's statutory authority; (3) made upon unlawful procedures; (4) affected by other error of law; (5) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or (6) manifestly erroneous in view of the reliable, probative and substantial evidence in the record.

It is well established that generally state regulations that are inconsistent with federal law are invalid under the Supremacy Clause. U.S.C.A. Const. Art. 6, cl. 2. Also, it is generally held that the Supremacy Clause applies to the regulatory

scheme promulgated under the Medicaid act. *See Frazar v. Gilbert*, 300 F. 3d 530 (5th Cir. 2002)[2]; *Missouri Child Care Ass'n v. Cross*, 294 F. 3d 1034 (8th Cir. 2002); *Antrican v. Odom*, 290 F. 3d 178 (4th Cir. 2002), *cert. denied*, 537 U.S. 973, 123 S. Ct. 467, 154 L. Ed. 2d 329 (2002). Although the narrow issue before us today is a matter of first impression for Louisiana, in the past we have found a denial of Medicaid benefits improper when based on a transfer of an annuity by an institutionalized spouse to a community spouse for her sole benefit. *See Pacente v. Jindal*, 99-0601 (La. App 4th Cir. 12/29/99), 751 So. 2d 343. However, case law in other states directly address annuities, the "state-payback" provision, and eligibility for Medicaid benefits and provide ample guidance.

---

[2] Reversed on other grounds.

In *Mertz v. Houstoun*, 155 F. Supp. 2d 415, 427 (E.D. Pa. 2001), where a Medicaid applicant sought a declaratory judgment that the denial of her application for benefits violated the Medicaid Act, the court recognized that:

> [A] couple may effectively convert countable resources into income of the community spouse which is not countable in determining Medicaid eligibility for the institutionalized spouse by purchasing an irrevocable actuarially sound commercial annuity for the sole benefit of the community spouse. It is a loophole apparently discerned by lawyers and exploited by issuers who advertise such annuities as a means to qualify for Medicaid benefits. . . . It is not the role of the court to compensate for an apparent legislative oversight by effectively rewriting a law to comport with one of the perceived or presumed purposes motivating its enactment. It is for the Congress to determine if and how this loophole should be closed.

In *James v. Richman*, No. Civ. A. 3:05-2647, 2006 WL 1169703 (M.D. Pa. Mar. 20, 2006), an institutionalized spouse was denied Medicaid benefits on the ground that an annuity purchased by

a community spouse was an available resource to be counted in determining institutionalized spouse Medicaid eligibility. Pennsylvania, like Louisiana, passed legislation which addressed irrevocable annuities and added restrictions including, "an annuity will be considered an available resource if the annuity names the Department as the residual beneficiary of any funds remaining due under the annuity at the time of death of the annuitant, not to exceed the amount of Medical Assistance expended on the individual during his or her lifetime." The *James* court opined, "the federal law is clear on the subject, and any change in federal law is a matter for Congress. The annuity such as the one present here is permitted and there can be no penalty." *Id.* at 4.

The most analogous case to the instant matter is *A.B. v. Division of Medical Assistance and*

Health Services, 865 A. 2d 701 (N.J. Super. 01/21/05), where a Medicaid applicant was denied Medicaid benefits due to her husband's refusal to name the state as a remainder beneficiary on an annuity. In that case, as in here, the husband purchased a commercial annuity to provide him with an income stream. In *A.B.*, the couple's daughter was designated as the remainder beneficiary. There, the court concluded that:

> [S]ince the Federal Medicaid Act prohibits the State from treating an actuarially sound commercial annuity as an available resource of the community spouse, the State may not require that it be named as the remainder beneficiary of such an annuity. The State cannot implement such a requirement either as an informal policy or as a regulation.

Id. at 468.

We agree. The Louisiana "state-payback" provision is inconsistent with the federal Medicaid Act and the directives of the Secretary of

Health and Hospitals. Therefore, it is unenforceable. Of notable interest is that LDHH explains, in brief and at oral arguments, that Louisiana's Medicaid Director was consulted in the drafting of the annuity provisions for the federal Deficit Reduction Act of 2005.[3] This, if effect, is an admission that Louisiana's MEM I-1634.2 annuity policy did not comport with federal statutory guidelines prior to the Deficit Reduction Act of 2005, and therefore was more restrictive.

No doubt the state was frustrated with the practice of what could be perceived as sheltering assets; indeed, it seems to be inconsistent with the intent of the Medicaid program which is to provide assistance to those truly in need. However, here the

[3] With the federal Deficit Reduction Act of 2005, effective February 8, 2006, Congress enacted legislation that now requires annuities to name the participating state as the residual beneficiary. The statute was not in effect at the time of Mrs. King's application.

state has gone beyond the scope of the cooperative federal-state program and hastily implemented a guideline that did not comply with the applicable preemptive federal statutes. After a thorough analysis of the record and the applicable law, we find LDHH's reliance on CMS approval for the validity of the "state-payback" provision misplaced. Accordingly, the record is clear that but for the annuity Mrs. King was entitled to LTC benefits.

CONCLUSION

For the reasons set forth above, we affirm the trial court's judgment finding that the "state-payback" provision, at the time of Renate King's application, was enforceable and that Renate is eligible for Long Term Medicaid benefits.

AFFIRMED.

STATE OF LOUISIANA
COURT OF APPEAL, SECOND CIRCUIT
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(318) 227-3700

Joan Carraway
Bossier Parish Clerk of Court
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Bruce Martin Bolin
Judge, 26th JDC
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DOHN Staff Attorney
P.O. Box 3836
Baton Rouge, LA 70821-3836

NOTICE OF JUDGMENT AND CERTIFICATE OF MAILING

April 4, 2007

DOCKET Number: **CA 06-42071**

RENATE KING

VERSUS

SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

NOTICE IS HEREBY GIVEN that the attached judgment and written opinion was rendered this date and a copy was mailed to the trial judge, the trial court clerk, all counsel of record and all parties not represented by counsel as listed above.

FOR THE COURT

Diana Pratt-Wyatt
Clerk of Court

RENATE KING	NUMBER: 119,360
VERSUS	26th JUDICIAL DISTRICT COURT
SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS	BOSSIER PARISH, LOUISIANA

WRITTEN REASONS FOR RULING

For reasons stated herein the decisions of the ALJ and DHH are reversed and this court declares that plaintiff Renate King is entitled to the benefits for which she applied.

The federal government must approve a Medicaid plan that is adopted by a state in order for that state to participate in the Medicaid Federal/State program. Louisiana has adopted the SSI standards. Louisiana has also adopted the Medicaid Eligibility Manual. Section 3240 of the

manual provides that a state may use resource eligibility methods which are more liberal than the SSI criteria, however they may not use any standard that is more restrictive. Federal regulations do not require that a person must name the state as a beneficiary under either an annuity that is an accountable resource or an annuity that is a non accountable resource.

This court finds that Louisiana's attempt to require a person to name the state as a beneficiary to an annuity to be a more restrictive standard than federal law allows. Therefore that portion of Louisiana's requirement that a person name the state as a beneficiary on an annuity is unenforceable and cannot be used to deny benefits to an applicant.

There is no factual dispute, and this court finds that the annuity meets all other points of the criteria necessary to exclude the annuity as an "accountable resource".

For the reasons stated herein the decisions of the ALJ and DHH are hereby reversed and this court declares that Renate King is entitled to the benefits for which she applied. Counsel for the plaintiff is instructed to prepare a judgment consistent with this opinion present it to opposing counsel for approval as to form and content and then to this court within twenty (20) days of this date.

THESE WRITTEN REASONS

RENDERED on the 15 day of August, 2006, in Benton, Bossier Parish, Louisiana.

BRUCE M. BOLIN
DISTRICT JUDGE

Please Serve:

Neal R. Elliott, Jr.
Post office Box 3836
Baton Rouge, LA 70802-3836

W. Alan Pesnell
Post Office Box 1794
Shreveport, Louisiana 71166-1794

RENATE KING	§	NUMBER 119360E
	§	
Plaintiff,	§	
	§	26th JUDICIAL
VERSUS	§	DISTRICT COURT
	§	
SECRETARY,	§	
LOUISIANA	§	BOSSIER PARISH,
DEPARTMENT OF	§	LOUISIANA
HEALTH AND	§	
HOSPITALS	§	
	§	ASSIGNMENT:
Defendant.	§	Judge Bolin

****

JUDGMENT

This matter was submitted for Judicial Review of the Administrative Agency Adjudication in the captioned matter, and this matter came before the Court for oral argument on August 7, 2006. Having considered the briefs of counsel, and after a review of the record, the law, and the evidence,

IT IS ORDERED, ADJUDGED and DECREED that there be judgment herein in favor of

Renate King, declaring that the Administrative Law Judge's ruling in the captioned matter was an error of law;

FURTHER ORDERED, ADJUDGED AND DECREED, that the ruling of the Administrative Law Judge from the hearing that occurred on January 11, 2006, be and it is hereby reversed;

FURTHER ORDERED, ADJUDGED AND DECREED, that the Petitioner, Renate King, is entitled to the long term care Medicaid benefits for which she applied, in accordance with law.

Judgment rendered on the 15th day of August, 2006.

Judgment read and signed in chambers, at Benton, Bossier Parish, Louisiana, on this the 7th day of September, 2006.

BRUCE M. BOLIN

HONORABLE BRUCE M. BOLIN, DISTRICT JUDGE
26TH JUDICIAL DISTRICT COURT

ENDORSED FILED 9-13-2006

/S/ PAULETTE B. GRIFFITH

A TRUE COPY - ATTEST

/S/ PAULETTE B. GRIFFITH
DEPUTY CLERK

APPROVED AS TO FORM AND CONTENT:

THE PESNELL LAW FIRM, APLC

By: /s/ W. Alan Pesnell
W. Alan Pesnell
Louisiana Bar Roll No. 23249

400 Travis Street, Suite 1100
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LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

By: /s/ Neal R. Elliott, Jr.

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APPEAL DECISION

In the Case of:

Renate King

Appeal #:

00 23 639

Identification #:

6670145193028

Filed: November 15, 2005

Heard: January 11, 2006

Appellant appealed the agency's decision to deny Long Term Care Coverage because Appellant's resources exceed the program limits of $2,000.00. A telephone hearing was conducted by the undersigned Administrative Law Judge. The following persons were present at the hearing: Lynne Beaird, Medicaid Analyst II, on behalf of the agency and Blake Rainey of Safe Planning and his attorney, Richard Woolbert, on behalf of Appellant.

ISSUE

Did the agency properly deny Long Term Care Coverage because Appellant's resources exceeded the program limit of $2,000.00?

APPLICABLE POLICY

I-1634.2 Annuities

For employment related annuities, refer to I-1634.33 Retirement Funds.

For Medicaid eligibility purposes an annuity is considered a legal instrument or device similar to a trust (Refer to page 3 of I-1720). An annuity is defined as a contract or agreement by which one receives fixed non variable payments on an investment for a lifetime or a specified number of years. An annuity containing a balloon payment will be considered an available resource. An annuity purchased by or for an individual using that individual's assets will be considered an available resource unless all of the following criteria are met. The annuity:

1. is irrevocable;

2. pays out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the annuitant, and

3. names the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual

beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime, and

4. is issued by an insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

Annuities which do not meet all of the above criteria must be amended to comply with these requirements. Annuities which do not provide for pay out of principal and interest in equal monthly 'installments and for which documentation is received from the issuing company that the "pay out" arrangements cannot be changed, will be considered to meet the new requirements once amended to name the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid fiends expended on the individual during his lifetime.

Note:

The Department of Insurance web site can be used to determine if a company is licensed and approved to do business in LA. The site is www.ldi.state.la.us. Use the Industry Search feature, at Search Forms use Company Search Form. The

name of the company is entered for the search.

Use Chart Z-1200 to determine actuarial life expectancy of the annuitant when necessary.

SUMMARY OF EVIDENCE

Appellant applied for Medicaid coverage and vendor payments for nursing facility care on August 8, 2005. Appellant was turned down for Medicaid coverage and vendor payments on October 18, 2005. The reason for the denial was resources in excess of the $2,000.00 program limit.

Appellant availed herself of the provision for Spousal Impoverishment. The Spousal Impoverishment allowable limit at the time of Appellant's application was $95,100.00. Appellant reported a checking account valued at $20,070.19, an annuity valued at $138,881.22, excess property valued at $44,000.00 and combined other assets valued at $21,293.21, for a total of $224,244.62. When the $95,100.00 Spousal Impoverishment amount was deducted, Appellant was left with $129,144.62 in assets. Thereby, leaving Appellant with resources in excess of the $2,000.00 limit.

Appellant's position is that the annuity should not be counted. If not counted, Appellant would have a total of $85,353.40 in assets. When the $95,100.00 is deducted, Appellant would be under the $2,000.00 resource limit.

Medicaid Eligibility Manual policy number I-1634.2 states that an annuity by or for an individual using that individual's assets will be considered an available resource unless four criteria are met. (Document # 10) In a letter dated September 7, 2005, Appellant's representative outlined which of Appellant's assets were used to purchase the annuity. (Document # 5) The primary beneficiary listed in the annuity is the William D. King Estate. (Document # 9) The third criteria to be met by the annuity is that the annuity must name the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime.

Appellant argued that the annuity has no cash value. The argument is based on the wording of the last page of the document which states that the annuity has no cash value. (Exhibit # A) "Equity value is the amount for which the resource can be expected to sell on the open market in the particular geographic area (fair market value) less legal encumbrances to the resource." (Exhibit # B, MEM I-1633) The money received from the annuity is considered as income on the Medicaid application. (Document # 4 B)

Appellant also argued that the agency could not apply MEM I-1634.2 because a 19th Judicial District Court judge signed an order, on July 18, 2005, granting a Temporary Injunction prohibiting the Secretary of the Louisiana Department of Health and Hospitals from the application and/or enforcement of the rule. (Exhibit # F) However, the

Temporary Injunction expired ten days later on July 28, 2005. Appellant did not apply for Medicaid until after the injunction had expired.

FINDINGS OF FACT

The undersigned Administrative Law Judge has carefully considered the entire available and credible evidence and based upon a preponderance of the evidence makes the following findings of fact:

1. Appellant applied for Medicaid coverage and vendor payments for nursing facility care on August 8, 2005.

2. The resource limit for Medicaid coverage and vendor payments is $2,000.00.

3. The Spousal Impoverishment allowable limit at the time of Appellant's application was $95,100.00.

4. Appellant was turned down for Medicaid coverage and vendor payments on October 18, 2005.

5. Appellant's assets were used to purchase an annuity in the amount of $138,881.22.

6. Under Medicaid policy an annuity is considered an available resource unless it meets all four of the listed criteria.

7. To not be counted as an available resource, the annuity must name the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds retraining in the annuity, not to

exceed any Medicaid funds expended on the individual during his lifetime.

8. The annuity names the William D. King Estate as the primary beneficiary.

9. The annuity does not meet all four of the required criteria necessary to remove it from the available resource status.

10. The annuity is an available resource.

11. Appellant's total resources after Spousal Impoverishment credit is $129,144.62.

12. Appellant's total resources exceed the $2,000.00 program limit.

LEGAL ANALYSIS AND CONCLUSION

Based on the above findings and in accordance with applicable policy, the agency correctly denied Appellant Medicaid coverage and vendor payments for nursing facility care. Appellant's annuity failed to meet all four of the required criteria to remove it from the status of an available resource.

RECOMMENDED DECISION: IN FAVOR OF THE AGENCY. UPHOLD THE AGENCY'S DECISION TO DENY APPELLANT MEDICAID COVERAGE AND VENDOR PAYMENTS FOR NURSING FACILITY CARE.

I hereby submit the foregoing report of the proceedings and my proposed decision and recommend its adoption as the decision of the Secretary of DHH.

_____

Mary M. Daly
Administrative Law Judge

STATE OF LOUISIANA
COURT OF APPEAL, SECOND CIRCUIT
401 Market Street, Suite 240
Shreveport, LA 71101
(318) 227-3700

Neal Risley Elliott Jr.
DOHH Staff Attorney
P.O. Box 3836
Baton Rouge, LA 70821-3836

REHEARING ACTION: May 3, 2007

Docket Number: 42,071-CA

RENATE KING

VERSUS

SECRETARY, LOUISIANA DEPARTMENT
OF HEALTH AND HOSPITALS

BEFORE JUDGES:
Henry N. Brown Jr.
Gay C. Gaskins
Richard Harmon Drew Jr.
Daniel Milton Moore III
John Larry Lolley

As counsel of record in the captioned case, you are hereby notified that the application for rehearing filed by State of Louisiana DOHH has this day been

DENIED.

FOR THE COURT
Diana Pratt-Wyatt
Clerk of Court

cc: William Alan Pesnell, Counsel for the Appellee

SECOND CIRCUIT COURT
OF APPEAL
STATE OF LOUISIANA
A TRUE COPY -- ATTEST

/s/
Clerk

THE SUPREME COURT OF THE STATE OF LOUISIANA

RENATE KING

VS. NO. 2007-C-1149

SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

IN RE: Department of Health & Hospitals Louisiana; – Defendant; Applying for Writ of Certiorari and/or Review, Parish of Bossier, Department of Health and Hospitals Bureau of Appeals, No. 00-23-639; 26th Judicial District court Div. E, Nos. 119,360; to the Court of Appeal, Second Circuit, No. 42,071-CA

September 14, 2007

Denied.

JTK

PFC

CDK

BJJ

CDT

JLW

Supreme Court of Louisiana
September 14, 2007

Carmen B. Young
Deputy Clerk of Court
For the Court

DEPARTMENT OF HEALTH AND HUMAN SERVICES		FORM APPROVED OMB NO. 0938-0193
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 04-18	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE July 1, 2004	
5. TYPE OF PLAN MATERIAL *(Check One):* ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT		
COMPLETE BLOCKS 6 THROUGH 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/ REGULATION CITATION: 42 CFR 436.601	7. FEDERAL BUDGET IMPACT: a. FFY 2004 $0.00 b. FFY 2005 $0.00	

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplemental 8b Attachment 2.6-A, Page 1	Same (TN 04-01)
Supplemental 9 to Attachment 2.6-A, Page 1d	Same (TN 03-09)

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to clarify the language for Medicaid eligibility -- treatment of annuities.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

The Governor does not review state plan material

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: Frederick P. Cerise, MD, MPH	
14. TITLE: Secretary	
15. DATE SUBMITTED: September 27, 2004	
FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 29 SEPTEMBER 2004	18. DATE APPROVED: 3 DECEMBER 2004
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July 2004	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: ANDREW A. FREDERICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH
23. REMARKS:	

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: LOUISIANA

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(R)(2) OF THE ACT*

☐ Section 1902(f) State ☐ Non-Section 1902(f) State

5. The Bureau of Health Services Financing eliminates the consideration of resources in determining Medicaid eligibility for the Low Income Families with Children and child related Medically Needy Programs.

6. An annuity meeting the criteria contained in Supplement 9 to Attachment 2.6-A, Page 1d, Item D, is considered resource in determining eligibility for individuals under 42 CFR 435.236.

7. The following will apply in the determination of Medicaid eligibility for the Medically Needy Program, Qualified Medicare Beneficiaries, Specified Low Income Beneficiaries, Qualified Individuals -- I, TB infected individuals, and the special income level group (individuals in a

medical institution for at least 30 consecutive days and individuals receiving home and community based waiver services for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard):

1. The maximum burial fund exclusion will be increased to $10,000.

2. The cash surrender value of life insurance and burial policies with a combined face value up to $10,000 will be disregarded.

8. For Working Individuals -- TWWIIA Basic Coverage Group

   - Legal spouse's share of community property and spouse's separate assets will be disregarded.

   - All life insurance policies will be disregarded.

   - Medical Savings accounts will be disregarded.

   - All retirement accounts will be disregarded, including private retirement accounts, such as IRA's and other individual accounts, and employer sponsored retirement accounts such as 401K plans, Keogh and employer pension plans

The above procedures in regard to trusts do not apply to trusts which provide that upon the death of such individual, the State will receive all amounts remaining in the trust up to an amount equal to the total medical assistance paid by Medicaid on behalf of the individual.

D. Annuities:

Effective January 1, 2003, the following shall govern annuities.

An annuity is defined as a contract or agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity containing a balloon payment will be considered an available resource. An annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria. The annuity:

1. is irrevocable;

2. pays out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient

amounts that the principal is paid out within the actuarial life expectancy of the annuitant;

3. names the State of Louisiana, Department of Health and Hospitals or its successor agency as the primary and permanent residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime; and

4. is issued by an insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

Annuities issued before January 1, 2003 which do not provide for pay out of principal and interest in equal monthly installments and for which documentation is received from the issuing company that the "pay out" arrangements cannot be changed, will be considered to met the new requirements once amended.

C

Effective: [See Text Amendments]

Code of Federal Regulations Currentness
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter C. Medical Assistance Programs
⊡ Part 430. Grants to States for Medical Assistance Programs (Refs & Annos)
⊡ Subpart B. State Plans

➔§ 430.14 Review of State plan material.

CMS regional staff reviews State plans and plan amendments, discusses any issues with the Medicaid agency, and consults with central office staff on questions regarding application of Federal policy.

SOURCE: 53 FR 36571, Sept. 21, 1988, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

42 C.F.R. § 430.14, **42 CFR § 430.14**

Current through November 21, 2007; 72 FR 65469

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END OF DOCUMENT

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C

Effective: [See Text Amendments]

Code of Federal Regulations Currentness
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter C. Medical Assistance Programs
⊡ Part 430. Grants to States for Medical Assistance Programs (Refs & Annos)
⊡ Subpart B. State Plans

➔§ 430.15 Basis and authority for action on State plan material.

(a) Basis for action.

(1) Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.

(2) Guidelines are furnished to assist in the interpretation of the regulations.

(b) Approval authority. The Regional Administrator exercises delegated authority to approve the State plan and plan amendments on the

basis of policy statements and precedents previously approved by the Administrator.

(c) Disapproval authority.

(1) The Administrator retains authority for determining that proposed plan material is not approvable or that previously approved material no longer meets the requirements for approval.

(2) The Administrator does not make a final determination of disapproval without first consulting the Secretary.

SOURCE: 53 FR 36571, Sept. 21, 1988, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

42 C.F.R. § 430.15, **42 CFR § 430.15**

Current through November 21, 2007; 72 FR 65469

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